Washington State Department of Health

Washington State Immunization Program
P.O. Box 47843 • Olympia, WA 98504-7843

PERINATAL HEPATITIS B CONFIDENTIAL CASE REPORT - MOTHER/INFANT

Please complete all sections of this form. See detailed instructions on back.

Section I: Mother's Information

MOTHER'S NAME | LAST | FIRST | MAIDEN | MOTHER'S DATE OF BIRTH

ADDRESS STREET | MOTHER'S HOME TELEPHONE ( )

CITY | STATE | ZIP | COUNTY | WORK OR MESSAGE TELEPHONE ( )

MOTHER'S RACE

❒ White ❒ Black ❒ Asian ❒ American Indian ❒ Hispanic ❒ Unknown ❒ Other (specify)

EDC (DATE) | DELIVERY HOSPITAL

MOTHER'S HEALTH CARE PROVIDER NAME **(OPTIONAL)** | PROVIDER'S TELEPHONE **(OPTIONAL)** ( )

PROVIDER'S STREET ADDRESS **(OPTIONAL)** | CITY | STATE | ZIP | COUNTY

DATE OF POSITIVE HBSAG TEST

ADMINISTERED BY ❒ Health Dept. ❒ Hospital ❒ Private Provider ❒ Unknown ❒ Other

PAYMENT SOURCE ❒ Insurance ❒ Medicaid ❒ None ❒ Unknown ❒ Other (specify)

Section II: Infant's Information

INFANT'S NAME | LAST | FIRST | MIDDLE INITIAL | SEX ❒ Female ❒ Male ❒ Unknown | DATE OF BIRTH

INFANT'S HEALTH CARE PROVIDER NAME **(OPTIONAL)** | PROVIDER'S TELEPHONE **(OPTIONAL)** ( )

PROVIDER'S STREET ADDRESS **(OPTIONAL)** | CITY | STATE | ZIP | COUNTY

Vaccine	Date	Vaccine Brand	Administered by	Payment Source
HBIG			❒ Health Dept. ❒ Unknown ❒ Hospital ❒ Other ❒ Private Provider	❒ Insurance ❒ Unknown ❒ Medicaid ❒ None ❒ Other (specify)
Vaccine Dose 1		❒ Recombivax ❒ Engerix ❒ Unknown	❒ Health Dept. ❒ Unknown ❒ Hospital ❒ Other ❒ Private Provider	❒ Insurance ❒ Unknown ❒ Medicaid ❒ None ❒ Other (specify)
Vaccine Dose 2		❒ Recombivax ❒ Engerix ❒ Unknown	❒ Health Dept. ❒ Unknown ❒ Hospital ❒ Other ❒ Private Provider	❒ Insurance ❒ Unknown ❒ Medicaid ❒ None ❒ Other (specify)
Vaccine Dose 3		❒ Recombivax ❒ Engerix ❒ Unknown	❒ Health Dept. ❒ Unknown ❒ Hospital ❒ Other ❒ Private Provider	❒ Insurance ❒ Unknown ❒ Medicaid ❒ None ❒ Other (specify)

Section III: Follow Up Serology (3-9 Months After Dose 3)

Test	Date	Results	Administered by	Payment Source
HBsAg		❒ Positive ❒ Negative ❒ Unk/Untested	❒ Health Dept. ❒ Unknown ❒ Hospital ❒ Other ❒ Private Provider	❒ Insurance ❒ Unknown ❒ Medicaid ❒ None ❒ Other (specify)
Anti-HBs		❒ Positive ❒ Negative ❒ Unk/Untested	❒ Health Dept. ❒ Unknown ❒ Hospital ❒ Other ❒ Private Provider	❒ Insurance ❒ Unknown ❒ Medicaid ❒ None ❒ Other (specify)

Section IV

Case Closed

❒ Moved ❒ Can't Locate ❒ Refuses Follow up ❒ False Positive ❒ Pregnancy Ended ❒ Other (specify)

Section V

MOTHER'S ID | CHILD'S ID | REPORT DATE

REPORTED BY NAME | PHONE | COUNTY

INSTRUCTIONS FOR COMPLETING PERINATAL HEPATITIS B CONFIDENTIAL CASE REPORT MOTHER/INFANT

1. Complete a case report form **only** for pregnant women who are HBsAg-positive during their pregnancy and infants born to HBsAg-positive women.

2. Complete the mother's information section as soon as the **HBsAg-positive test result** is known. Keep the original case report for your files and send a copy of the case report to the Immunization Program.

3. Using the same case report as the mother's, complete the infant's information section, including the information on **HBIG** and hepatitis B vaccine **Dose #1** as soon as the infant is born. Keep the original case report for your files and send a copy of the updated case report to the Immunization Program.

4. Complete the information on hepatitis B vaccine **Dose #2** as soon as the information is known. Keep the original case report for your files and send a copy of the updated case report to the Immunization Program.

5. Complete the information on hepatitis B vaccine **Dose #3** as soon as the information is known. Keep the original case report for your files and send a copy of the updated case report to the Immunization Program.

6. Complete the **follow-up serology** information as soon as the results are known. Keep the completed original case report for your files and send a copy of the completed case report to the Immunization Program.

Summary: One form should be completed for one mother and her infant with each pregnancy. The forms should be completed and copies sent to the Immunization Program at the following times:

1. After HBsAg-positive test on mother
2. After birth of infant and vaccination with HBIG and Dose #1
3. After vaccination with Dose #2
4. After vaccination with Dose #3
5. After follow-up serology
6. After mother/infant case is closed

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